SD

UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA, Plaintiff, v. THE CITY OF PHILADELPHIA; EDWARD G. RENDELL, MAYOR OF THE CITY OF PHILADELPHIA; ESTELLE B. RICHMAN, COMMISSIONER, HEALTH DEPARTMENT; EPISCOPAL LONG TERM CARE, AS OPERATORS OF THE PHILADELPHIA NURSING HOME, Defendants.	Civ. No. 98- 4253

COMPLAINT

1. The Attorney General of the United States brings this action on behalf of the United States of America, pursuant to the Civil Rights of Institutionalized Persons Act of 1980 ("CRIPA"), 42 U.S.C. § 1997, to enjoin the named Defendants from depriving persons residing at the Philadelphia Nursing Home ("PNH") of their legal rights, and of rights, privileges or immunities secured or protected by the Constitution of the United States and federal statutes.

2. The United States of America, through the United States Attorney for the Eastern District of Pennsylvania, also brings this civil action under the False Claims Act, 31 U.S.C. §§ 3729 et seq., and alleges that the City of Philadelphia, PNH, and Episcopal Long-Term Care, submitted or caused the submission of false or fraudulent claims to the United States for payment for care that was not adequately rendered to elderly individuals, to individuals with developmental disabilities, and to individuals with mental illness residing at PNH.

JURISDICTION, STANDING AND VENUE

3. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1345 and 31 U.S.C. §§ 3729 et seq.

4. The United States has standing to maintain this action pursuant to 42 U.S.C. § 1997a and 31 U.S.C. §§ 3730 and 3732.

5. The Attorney General has certified that all pre-filing requirements specified in 42 U.S.C. § 1997b have been met. The Certificate of the Attorney General is appended to this Complaint and is incorporated herein.

6. Venue is proper in the United States District Court for the Eastern District of Pennsylvania pursuant to 28 U.S.C. §§ 1391(b) and (c). All claims set forth in the Complaint arose in said District.

PARTIES

7. Plaintiff is the UNITED STATES OF AMERICA acting for itself, and on behalf of the Department of Health and Human Services, Office of Inspector General, the Medicare Trust Fund, the Medical Assistance Program, and the beneficiaries thereof.

8. Defendant CITY OF PHILADELPHIA ("City") owns PNH, a nursing home housing individuals with special needs including the elderly, those with developmental disabilities, and those with mental illness, located in Philadelphia, Pennsylvania.

9. Defendant EDWARD G. RENDELL is the Mayor of the City of Philadelphia, and in this capacity heads the Executive Branch of the City's government and, among other duties, reviews and approves budget requests submitted by Executive Branch agencies. He selects and appoints the Commissioner of the City's Health Department.

10. Defendant ESTELLE B. RICHMAN is the Commissioner of the City's Health Department and, in this capacity, exercises administrative control of, and responsibility for, PNH.

11. Defendant EPISCOPAL LONG TERM CARE ("ELTC") is the operator of PNH pursuant to a contract with the City, and is responsible for the day-to-day operations of PNH.

12. The individual Defendants named in ¶¶ 9 and 10 above are officers of the Executive Branch of the City of Philadelphia and are sued in their official capacities.

13. PNH is an institution as that term is defined in 42 U.S.C. §§ 1997(1)(A), (1)(B)(i) and (1)(B)(v).

14. Defendants are legally responsible, in whole or in part, for the operation of and conditions at PNH, as well as for the care and treatment of persons residing at that institution.

15. At all relevant times, Defendants have acted or failed to act, as alleged herein, under color of state law.

NURSING HOME REFORM ACT

16. The Nursing Home Reform Act (the "Act") mandates that nursing facilities comply with federal requirements relating to the provision of services. 42 U.S.C. §§ 1396r et seq. See also 42 U.S.C. §§ 1395i-3 et seq. Specifically, in terms of the quality of life for residents of nursing facilities, the Act states that: "A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." 42 U.S.C. § 1396r(b)(1)(A). See also 42 U.S.C. § 1395i-3(b)(1)(A); 42 C.F.R. § 483.15.

17. In addition, the Act mandates that a nursing facility:

> provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which —
>
> (A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;...

42 U.S.C. § 1396r(b)(2)(A). See also 42 U.S.C. § 1395i-3(b)(2)(A); 42 C.F.R. § 483.25.

18. A duty is placed on the nursing facility to fulfill the residents' care plans by providing, or arranging for the provision of, inter alia, nursing and related services and medically-related social services that attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, pharmaceutical services, and dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident, and treatment and services required by residents with mental illness and/or mental retardation. 42 U.S.C. §§ 1396r(b)(4)(A)(i-vii). See also 42 U.S.C. §§ 1395i-3(b)(4)(A)(i-vii).

19. The Act mandates that nursing homes that participate in the Medical Assistance Program ("Medicaid") and the Medicare Program meet certain specific requirements in order to qualify for such participation. These requirements are set forth at

42 C.F.R. §§ 483.1 et seq. and "serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid." 42 C.F.R. § 483.1(b).

20. Federal regulations, when addressing quality of care concerns, mandate that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25.

21. As a pre-requisite to enrollment as a provider in the Medicaid Program, PNH entered into a provider agreement and agreed to the following provisions:

> 1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items from which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.
>
> *******
>
> 5. That the Facility's participation in the [Medicaid] Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the [Medicaid] Program.

22. At all times relevant to this action, PNH was a "provider" with a valid provider agreement with the Pennsylvania Department of Public Welfare.

FACTUAL ALLEGATIONS

COUNT I: CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT

23. The above paragraphs are incorporated herein by reference as if fully set forth.

24. Defendants have failed to ensure the reasonable safety and personal security of the PNH residents. Defendants have failed to adequately supervise, monitor and protect the residents from harm and risk of harm.

25. Defendants have failed to provide adequate basic care and related services to PNH residents.

26. Defendants have failed to provide residents with adequate, appropriate and meaningful activities.

27. Defendants have failed to ensure that PNH residents are free from undue or unreasonable restraint and that restraints are administered to PNH residents by appropriately qualified professionals in keeping with accepted professional standards, and are not used as punishment, in lieu of treatment, or for the convenience of staff.

28. Defendants have failed to provide adequate mental health care and services to PNH residents.

29. Defendants have failed to provide adequate medical and health care and services to PNH residents and to ensure that medications are prescribed and administered to PNH residents by appropriately qualified professionals in keeping with accepted professional standards, and are not used as punishment, in lieu of treatment, or for the convenience of staff.

30. Defendants have failed to provide adequate nursing care and services to PNH residents.

31. Defendants have failed to provide adequate physical and occupational therapy services to PNH residents.

32. Defendants have failed to provide a sufficient number of adequately trained professional and direct care staff to render the essential care and treatment outlined above in paragraphs 24 through 31.

33. Defendants have failed to ensure that PNH residents are evaluated by appropriate professionals for placement in the most integrated setting and appropriately placed into the most integrated setting according to their individualized needs.

34. Defendants have failed to meet the requirements of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C.

§§ 12101 et seq., and the regulations promulgated pursuant thereto, by excluding the PNH residents, by reason of their disability, from participation in or by denying them the benefits of the services, programs, or activities of the City, or by subjecting them to discrimination, and by failing to administer services, programs, and activities in the most integrated setting appropriate to their needs. For purposes of Title II of the ADA, the Defendants are a "public entity," and the residents of PNH are "qualified individual[s] with a disability."

35. Defendants have failed to meet the requirements of the Medicaid Program established under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396r et seq., and the regulations promulgated pursuant thereto.

36. Defendants have failed to meet the requirements of the Medicare Program established under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395i-3 et seq., and the regulations promulgated pursuant thereto.

37. The acts and omissions alleged in paragraphs 24 through 36 infringe upon the PNH residents' legal rights and substantive liberty interests and constitute resistance to their full enjoyment of rights, privileges or immunities secured or protected by the Constitution or laws of the United States, and

deprive the PNH residents of such rights, privileges or immunities.

38. Unless restrained by this Court, Defendants will continue to engage in the conduct and practices set forth in paragraphs 24 through 36 that deprive residents of PNH of their legal rights under law and the rights, privileges, or immunities secured or protected by the Constitution of the United States, and cause irreparable harm to PNH residents.

COUNT II: FALSE CLAIMS ACT

39. The above paragraphs are incorporated herein by reference as if fully set forth.

40. The United States charges that the Defendants submitted or caused the submission of false or fraudulent claims to the United States for payment for care that was not adequately rendered to elderly individuals, to individuals with special needs, to individuals with developmental disabilities, and to individuals with mental illness residing at PNH.

41. PNH is a licensed long-term care (nursing) facility under federal and state law and is certified to participate in the Medicaid and Medicare Programs.

42. A synopsis of the factual basis for which this cause of action is based is incorporated herein and is attached hereto as

Exhibit A.

43. The provision of adequate medical care, nursing care and psychiatric care, pertaining to the appropriate use of psychotropic drugs for PNH residents and monitoring for side-effects of these medications, was the responsibility of PNH medical and nursing staff.

44. The provision of adequate wound care to PNH residents was the responsibility of the PNH nursing and medical staff.

45. The provision of adequate nutrition to PNH residents was the responsibility of not only the PNH nutritionists and dietary staff but included the PNH nursing and medical staff as well.

46. The provision of a safe environment in which PNH residents were free from any abuse, included all PNH disciplines, including but not limited to PNH medical, nursing, and facility management staff.

47. Defendants' agents and/or employees were responsible for the provision of medical care, nursing care, psychiatric care, appropriate medications and monitoring thereof, wound care, nutritional services, and safe conditions for all of the PNH residents.

48. Defendants' agents and/or employees billed the United

States (through the Pennsylvania Department of Public Welfare) for care provided to the PNH residents for reimbursement by the Medicaid Program. Defendants' agents and/or employees billed the United States for care provided to the PNH residents for reimbursement by the Medicare Program.

49. Defendants' agents and/or employees submitted or caused to be submitted false or fraudulent claims to the Medicaid and Medicare Programs for payment or approval of the provision of medical care, nursing care, psychiatric care, appropriate medications and monitoring thereof, wound care, nutritional services, and safe conditions that were not adequately rendered to PNH residents for the time period January 1995 through December 1996.

50. Defendant City of Philadelphia, as licensee for PNH, was responsible for the care rendered to residents at PNH and submitted or caused to be submitted the repeated submission of false or fraudulent claims for payment or approval to the Medicaid and Medicare Programs, for the provision of medical care, nursing care, psychiatric care, appropriate medications and monitoring thereof, wound care, nutritional services, and safe conditions that were not adequately rendered to PNH residents for the period January 1995 through December 1996. 31 U.S.C. § 3729.

51. Defendants knowingly did not ascertain the truth or falsity of the claims for services submitted or caused to be submitted to the Medicaid and Medicare Programs, for payment or approval on behalf of PNH residents, all of whom were Medicaid recipients and/or Medicare beneficiaries. 31 U.S.C. § 3729.

52. Defendants acted in reckless disregard and/or deliberate ignorance of the care and services ordered and actually provided to PNH residents when billing the Medicaid and Medicare Programs. 31 U.S.C. § 3729.

53. Upon information and belief, the United States alleges that the care rendered to the residents identified in Exhibit A was representative of the care rendered to residents of PNH. The claims for reimbursement for the care of these residents would thus constitute false claims actionable under the False Claims Act to the same extent as the claims for the individuals identified in Exhibit A.

54. The United States was damaged as a result of the conduct described above.

COUNT III: UNJUST ENRICHMENT

55. The above paragraphs are incorporated herein by reference as if fully set forth.

56. The conduct described in the foregoing paragraphs caused all Defendants to receive, directly or indirectly, benefits from the United States.

57. Under the circumstances described in the foregoing paragraphs, as between the United States and each Defendant in this Count, retention by each Defendant of the benefits conferred by the United States would be unjust.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, the United States of America, prays, with regard to Count I of this Complaint, that this Court enter an order permanently enjoining Defendants, their agents, employees, subordinates, successors in office, and all those acting in concert or participation with them from continuing the acts, practices and omissions at PNH set forth in paragraphs 24 through 36 above, and to require Defendants to take such action as will provide legal and constitutional conditions of care to persons who reside at PNH. The United States further prays that this Court grant such other and further equitable relief as it may deem just and proper.

WHEREFORE, Plaintiff, the United States of America, demands and prays, with regard to Count II of this Complaint, that judgment be entered in its favor and against the Defendants,

jointly and severally, as follows:

a. an amount equal to the number of false or fraudulent claims that will be proven at trial, multiplied as provided for in 31 U.S.C. § 3729(a), and imposition of $10,000.00 per claim;

b. three times that total amount of damages sustained by the United States because of the acts complained of;

c. costs of this action;

d. such other and further relief as the Court shall deem proper.

WHEREFORE, Plaintiff, the United States of America, demands and prays, with regard to Count III of this Complaint, that judgment be entered in its favor and against the Defendants, jointly and severally, as follows:

a. an amount equal to the gain to the Defendants as a result of the activities complained of;

b. interest according to law;

c. costs of this action; and

d. such other and further relief as this Court may deem proper.

Respectfully submitted,

JANET RENO
Attorney General of the
United States

BILL LANN LEE
Acting Assistant
Attorney General
Civil Rights Division

MICHAEL R. STILES
U.S. Attorney
Eastern District of
Pennsylvania

JAMES G. SHEEHAN
Assistant U.S. Attorney
Chief
Civil Division
Eastern District of
Pennsylvania

STEVEN H. ROSENBAUM
Chief
Special Litigation Section

ROBINSUE FROHBOESE
Deputy Chief
Special Litigation Section

DAVID R. HOFFMAN
Assistant U.S. Attorney
Eastern District of
Pennsylvania
615 Chestnut Street
Suite 1250
Philadelphia, PA 19106
(215) 451-5337

RICHARD J. FARANO
Senior Trial Attorney
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
P.O. Box 66400
Washington, DC 20035-6400
(202) 307-3116

Office of the Attorney General
Washington, D. C. 20530

CERTIFICATE OF THE ATTORNEY GENERAL

I, Janet Reno, Attorney General of the United States, certify that with regard to the foregoing Complaint, United States v. City of Philadelphia, et al., I have complied with all subsections of 42 U.S.C. § 1997b(a)(1). I certify as well that I have complied with all subsections of 42 U.S.C. § 1997b(a)(2). I further certify, pursuant to 42 U.S.C. § 1997b(a)(3), my belief that this action by the United States is of general public importance and will materially further the vindication of rights, privileges or immunities secured or protected by the Constitution or laws of the United States.

In addition, I certify that I have "reasonable cause to believe" as set forth in 42 U.S.C. § 1997a to initiate this action. Finally, I certify that all prerequisites to the initiation of this suit under 42 U.S.C. § 1997, et seq., have been met.

Pursuant to 42 U.S.C. § 1997a(c), I have personally signed the foregoing Complaint. Pursuant to 42 U.S.C. § 1997b(b), I am personally signing this Certificate.

Signed this 7 day of August, 1998, at Washington, D.C.

Janet Reno

JANET RENO
Attorney General
of the United States

EXHIBIT A

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

December 19, 1996

The Honorable Edward G. Rendell
Mayor of the City of Philadelphia
Office of the Mayor
215 City Hall
Philadelphia, PA 19107

Re: Investigation of the Philadelphia Nursing Home

Dear Mayor Rendell:

On July 28, 1995, we notified you, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, of our intent to investigate conditions at the Philadelphia Nursing Home ("PNH") in Philadelphia, Pennsylvania. We conducted our investigation by reviewing facility records, including residents' medical charts and other documents relating to the care and treatment of PNH residents, interviewing administrators, staff, and residents, and conducting on-site tours of the facility with three expert consultants: Blaine S. Greenwald, M.D., a geriatric psychiatrist, Ronald D. Adelman, M.D., a geriatric physician, and Geraldine Mendelson, R.N., M.Ed., M.A., C.N.A.A., a geriatric nurse. Following these tours, we obtained and analyzed survey reports from independent consultants retained by the City to evaluate conditions at PNH. Consistent with CRIPA's statutory requirements, we are now writing to inform you of our findings.

Based on our comprehensive investigative review, we have concluded that there are numerous conditions and practices at PNH that violate the constitutional and federal statutory rights of PNH residents. This conclusion should come as little surprise given that throughout our visit, a number of PNH administrators and professional and direct care staff readily admitted that many service areas were insufficient and needed remedial attention. Our independent conclusions and findings were also supported by the conclusions and findings contained in the City's own documents summarizing its many internally generated on-site reviews of the facility. We have set forth below the facts supporting our findings of unlawful and unconstitutional conditions at PNH.

Before addressing the substantive violations, we would like to express our appreciation to the PNH administrators and staff and the City of Philadelphia representatives who extended their

cooperation and courtesy while we visited the facility. We would especially like to recognize Mollie Hess, Executive Director of PNH, and Jim Casey of PNH for their professionalism, hard work and diligent efforts in supplying us with the information we needed to conduct a thorough and accurate investigation of PNH. Indeed, both repeatedly stressed their sincere desire to improve conditions and practices at the facility. We hope to be able to continue to work with the City and PNH officials in such an atmosphere of cooperation and good faith.

I. PNH IS FAILING TO ENSURE THE SAFETY OF ITS RESIDENTS AND TO PROVIDE ADEQUATELY FOR THEIR BASIC CARE NEEDS

Individuals residing in a state or municipally operated institution have a fundamental Fourteenth Amendment due process right to basic care and reasonably safe conditions. Youngberg v. Romeo, 457 U.S. 307 (1982). Federal statutes governing the operation of nursing homes create similar rights. See, e.g., Grants to States for Medical Assistance Programs (Medicaid), 42 U.S.C. § 1396r, Health Insurance for Aged and Disabled (Medicare), 42 U.S.C. § 1395i-3, and their implementing regulations, 42 C.F.R. § 483, Subpart B. PNH fails to provide adequately for the most basic care needs of many of its residents and fails to ensure resident safety, thereby violating the legal rights of its residents.

A. PNH Fails To Ensure Resident Safety

PNH violates residents' rights by failing to provide a safe environment. Protection from harm is a fundamental constitutional right and a basic requirement of facilities, such as PNH, receiving Medicare and Medicaid funds. Youngberg v. Romeo, 457 U.S. 307 (1982); 42 C.F.R. §§ 483.13, 483.15 (residents have the right to be free from verbal, sexual, physical, and mental abuse, and corporal punishment; the facility must also provide a "safe" environment).

The facility's incident reports and special abuse investigations reveal a high level of injuries and dangerous situations that place residents at risk of harm. Many of these incidents are preventable and reflect systemic deficiencies at PNH including lack of adequate staffing, failure to supervise residents, and inadequate assessment and treatment of mental illness, cognitive impairments, and behavior problems. A number of the incidents result from aggressive PNH residents attacking other residents. For example, in the space of a few weeks during the summer months just prior to our tour, the following incidents occurred at PNH: J.S "assaulted" J.C. by punching her in her left eye; a day earlier, J.S. punched her in the right jaw; F.F. punched W.W. in the head and chest and hit D.D. giving her a bruised eye; T.W. "attacked" J.F. with a glass vase, striking him on the head causing an occipital laceration; B.W. and P.S. were

hitting each other on the arms and shoulders; N.S. entered B.M.'s room and punched her in the face; C.Q. punched E.M. in the chest; J.R. hit A.S. three times in the head causing a lump on A.S.'s head; J.R. threw a cup of coffee and his walker at E.A.; and V.M. hit N.S. in the chest. During the same few weeks, a PNH aide allegedly "started slapping Mr. E. [a resident] in the face." Other injuries and harmful situations have resulted from unsupervised residents who elope or abuse alcohol while in the facility. These are merely representative examples of other similar preventable incidents that are routinely occurring throughout the facility that demonstrate a systemic failure to protect residents from harm.

B. PNH Often Fails To Provide Basic Care To Residents

PNH also often fails to meet the most basic care needs of its residents. While we found a relatively clean facility at the time of our tour, we also uncovered a number of disturbing examples where residents' basic care needs were not met. For example, we discovered foul odors on residents and in resident rooms, and unkempt and dirty residents wearing unsanitary clothes that were malodorous and covered with food or fluid. Upon smelling a "severe urine odor" coming from one resident's room, our nurse consultant discovered a resident in a bed that was soaking wet in which he had apparently been left for some time. Dr. Greenwald reports that the "stench was hardly bearable" in another resident's room. Dr. Greenwald concludes that these "neglectful situations could be interpreted as a kind of passive abuse ... [which] trespassed beyond the typical range of hygienic conditions that one encounters in nursing homes." During our tour, several PNH care aides freely admitted dismay about the lack of staff concern and attention paid to the residents' basic care needs.

The City has documented similar problems in its on-site reviews of conditions at PNH. For instance, City surveyors in March 1995 found "a lack of overall cleanliness [at PNH]. Odors were prevalent throughout the building, residents' rooms were unkempt, wheelchairs and geri chairs were dirty and in ill repair." Perhaps most troubling was the City surveyors' conclusion that PNH failed to remedy these basic care problems even after having been alerted to them on prior occasions.

A number of different PNH residents spoke to us freely and at length about the many substandard conditions and practices at PNH. The independent observations and conclusions of the residents reinforced one another as our tour progressed. Some residents complained that units are short-staffed, especially on the weekends and evenings, and that staff members generally do not assist the residents. Virtually all residents we spoke to complained that PNH nurses failed to respond in a timely fashion to their calls for assistance. One resident felt that conditions

had improved somewhat since the recent arrival of the newer health care staff, but he felt that the newer staff members were inexperienced and not properly trained to care for the population at PNH. Most troubling, this resident expressed concern about the staff's slow response to his emergency needs. He related that when he has experienced shortness of breath, experienced a rapid heartbeat, or has run out of his supply of oxygen, it has taken PNH staff twenty minutes to come to help him. This conclusion is consistent with the City's independent on-site review findings in October 1995 that a number of PNH staff do not tend to the residents' needs while on duty, including residents who have medical orders to receive one-to-one supervision.

In addition, more than one resident indicated that the PNH staff members are generally insensitive towards the residents, that the PNH aides talk to the residents with a disrespectful, often verbally abusive tone, and that their personal belongings are stolen. The PNH administration, having taken the positive step of regularly attending resident council meetings, acknowledged to us that many of the residents' concerns are legitimate.

II. PNH FAILS TO PROVIDE ADEQUATE ACTIVITIES TO RESIDENTS AND USES UNREASONABLE RESTRAINTS

PNH is failing to engage its residents in adequate, appropriate and meaningful activities in violation of their federal statutory rights. See, e.g., 42 C.F.R. § 483.15 ("facility must provide for an ongoing program of activities designed to meet ... the interests and the physical, mental, and psychosocial well-being of each resident").

Even the City's on-site review has uncovered that often no activities take place at PNH and that "[t]here are not enough activities scheduled for the diversity of this population." The City's November 1995 on-site review discovered PNH activities staff reading the newspaper, listening to the radio or watching television instead of engaging the residents in activities. PNH residents have expressed similar concerns.

One consequence of the lack of meaningful activity may be resident abuse of alcohol resulting from boredom and lack of staff supervision and involvement with residents. This problem appears to be widespread at PNH. For example, the City's October 1995 on-site review reveals that one verbally abusive and physically aggressive resident had a persistent problem with "smelling of alcohol," and being found sleeping in the lounge with bottles of alcohol present. An August 11, 1995 PNH special abuse notification letter indicates that another resident left the facility in his wheelchair via the front gate while he was intoxicated. During our tour, one PNH mental health consultant

acknowledged that there is a great need for programming and treatment for residents with alcoholism at PNH.

In addition, PNH frequently uses restraints as a substitute for keeping the residents engaged. This practice violates the constitutional and federal statutory rights of residents. Youngberg v. Romeo, 457 U.S. 307 (1982); 42 C.F.R. § 483.13 ("resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms").

Moreover, PNH restraint practices do not comport with accepted professional standards. During our tour, we discovered that many residents were in restraints or in bed with the bed rails up, restricting their ability to leave the bed, without proper physicians' orders. Indeed, PNH is failing to provide its residents with adequate evaluations prior to the use of or initiation of an order for restraints. The City's own on-site reviews of PNH confirm our findings.[1]/ We also found that some residents were not released from their restraints every two hours as is generally accepted. These inappropriate restraint practices violate PNH residents' rights.

III. PNH IS FAILING TO PROVIDE ADEQUATE HEALTH CARE FOR ITS RESIDENTS

In addition to basic care and safety, all residents of state or municipally operated institutional facilities have a fundamental Fourteenth Amendment due process right to adequate health care. Youngberg v. Romeo, 457 U.S. 307 (1982). See also 42 U.S.C. § 1396r(b)(4)(A), 42 U.S.C. § 1395i-3(b)(4)(A) (facility must provide for medical, nursing and related services to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," and provide adequate treatment and services required by mentally ill and mentally retarded residents), and their implementing regulations, 42 C.F.R. § 483, Subpart B. However, PNH fails to provide its residents with medical, nursing and psychiatric care and services that comport with generally accepted practices.

---

[1]/ For example, the November 1995 on-site review indicates "no orders when restraint use indicated in record ... orders for side rails many times not seen ... no assessment of restraint use." Similarly, the October on-site review reveals: "[s]ide rails up on beds throughout facility, but no orders for them"; "[e]vening shift documents that side rails are up, but no physician's order is seen"; "[n]ursing documented at 10 p.m. that side rails were up, but no order was written for them." The September on-site review again reveals that PNH often places residents in restraints without proper orders: "use of 'leg restraint' - no order seen for such"; "[r]esident needs order for side rails."

A. Psychiatric Practices And Mental Health Services Are Inadequate And Do Not Meet The Needs Of The Residents

PNH is not providing its mentally ill residents with adequate psychiatric and mental health services in accordance with generally accepted standards. Psychiatric practices at PNH are typically characterized by superficial evaluations, inadequate follow-ups, a lack of non-drug treatment approaches, a lack of cogent treatment planning, a lack of multidisciplinary input into psychiatric treatment decisionmaking, and a lack of psychiatric inservices.

The City, through its on-site review documents and the statements of its employees, readily admits deficiencies in mental health services at PNH. For example, the City's own November 1995 on-site review reveals "zero percent" compliance with professional standards in its review of antipsychotic therapy at PNH. During our tour, both PNH's mental health consultants and nurses freely admitted deficiencies in psychiatric care and mental health services at PNH.

1. Mental Health Assessments, Diagnoses And Treatments Are Inappropriate

PNH is generally failing to appropriately assess, diagnose and treat its residents who need mental health services. For example, although many residents have cognitive impairments and dementia, PNH does not perform proper cognitive examinations and does not develop adequate and appropriate dementia work-ups. These failures can lead to needless resident deterioration and to the development of irreversible conditions in residents that might have been reversible. In addition, PNH charts often lack consistent or appropriate diagnoses. An adequate diagnosis is essential to develop appropriate treatment. As Dr. Greenwald notes, an inadequate diagnosis "can lead to improper treatment that could harm the resident, either by subjecting him or her to needless medication and its attendant side effects, and/or by failing to treat the underlying mental illness, thereby exposing the resident to negative target behaviors that are not properly controlled."

As a result of the flawed assessment process and inadequate diagnostic formulation, treatments are often not appropriate. For example, several PNH residents have been inappropriately placed on multiple psychotropic drugs without clearly documented benefit. Such polypharmacy treatment places these residents at unnecessary risk of harm of medication side effects and improperly medicates them without the benefit of productively treating their mental illness. In this regard, Dr. Greenwald concludes that PNH has engaged in "cavalier" polypharmacy practice which is "dangerous," and "likely-to-be harmful."

PNH also fails to provide its residents with adequate and necessary non-drug mental health services. Resident care plans generally fail to substantively address mental health treatment. A number of PNH residents who could benefit from psychosocial treatment do not receive these services. Because of this, Dr. Greenwald concludes that the residents "may remain mired in a state of institutionalized dysfunctionality, when their potential to improve may be significant."

Moreover, there is a marked discrepancy between published PNH policies and the reality of practice at PNH. Contrary to what is written in the Administrative Policies and Procedures guidelines, care plans do not seriously "build on resident's strengths" or "have treatment objectives with measurable outcomes" that are actually measured, and the facility does not ensure that residents "who use antipsychotic drugs receive gradual dose reductions, drug holidays or behavioral programming."

2. Psychiatric Drug Side Effects Monitoring Is Inadequate

Medication side effects monitoring at PNH is inadequate and fails to meet generally accepted standards. Residents are often needlessly subjected to the risks of side effects of the treating medication, thus further exacerbating their already fragile condition. Because of the increased sensitivity to medications among the elderly, it is important that PNH actively monitor side effects. However, PNH does not provide adequate side effects monitoring. For example, PNH's abnormal involuntary movement monitoring is inconsistent at best and typically inaccurate. This failure is especially troubling given that some abnormal involuntary movement side effects associated with antipsychotics may be irreversible for some of the residents.

PNH chart notes rarely reflect that specific drug side effects are considered in the treatment equation. The consult psychiatrist has largely abdicated side effect monitoring for antipsychotics to a form that nurses are supposed to fill out, but rarely if ever do. Several PNH nursing staff even admitted to us that they do not know what side effects to look for. We found that side effects data collection is inadequate in that the PNH forms are haphazardly filled out and, when they are filled out, are often inaccurate. The City's on-site review findings consistently confirm these deficiencies in side effects monitoring.

As a result of these deficiencies, PNH often chronically administers psychotropic medications that have not proven to be effective. PNH therefore unnecessarily subjects its residents to medication side effects. Dr. Greenwald concludes that the consequence of this practice is that "potentially successful psychiatric treatment and rehabilitation is undermined, and in

selected residents, longer-than-necessary institutionalization maintained and potential re-entry to mainstream society derailed. All of these deficiencies contribute to either harming the residents or placing them at increased risk of harm."

3. Psychiatric Progress Notes, Forms And Documentation Are Inadequate

Psychiatric chart documentation at PNH is inadequate and conveys little meaningful information. Our experts found that progress notes, behavior/side effect monitoring forms, and problem lists do not accurately summarize current clinical circumstances. The PNH notes are usually superficial, employ generalities, are not tied to residents' symptoms or diagnoses, and do not identify goals of treatment. Moreover, even when clinical findings are documented, they often do not yield appropriate and needed treatments.

4. Mental Health Resources And Expertise Are Insufficient

PNH does not provide a sufficient number of psychiatry consult hours to meet the needs of the residents. The current consult psychiatrist admitted that he did not see every resident with mental illness at PNH at least once a year as required by professional standards. In fact, he admitted that he only sees residents on a referral basis rather than proactively instituting a case-identification protocol and appropriate follow-up system. As a result, the psychiatrist admitted that some residents have not been seen who should have been seen simply because no referral had been made. Indeed, Dr. Greenwald found residents with mental illness who have exhibited violent or threatening behaviors who have not had any psychiatric consultations. Even the new PNH mental health team acknowledged that more psychiatric time was necessary at PNH given the large number of residents with mental health concerns.

We uncovered several instances where a psychiatric consult was ordered but the psychiatrist did not actually see the resident for weeks. This practice is improper and compromises attentive resident care because the condition prompting the psychiatric consult may become dramatically exacerbated in the intervening weeks. Dr. Greenwald found that it produces the likelihood of "untoward and potentially dangerous" incidents that could occur, placing the resident or others at risk of harm.

Overall, Dr. Greenwald concludes that "this kind of loose oversight compromises patient care and is heavily dependent upon good nursing staff-psychiatrist communication. However, at PNH, nursing staff-psychiatrist communication is erratic and superficial." There is little if any multidisciplinary involvement in psychiatric treatment decisionmaking at PNH. We found little evidence that the treating psychiatrist is aware of,

or has explored, considered and incorporated relevant and important nursing information. The City's own on-site reviews document that the consult psychiatrist fails to consider important behavioral information contained in the nursing notes.

In addition, there is a general need for continuing education among the PNH staff at large with respect to mental health and psychiatric concerns among its residents. There is a conspicuous lack of continuing education and inservices regarding mental health issues at PNH.

B. Medical Care And Services At PNH Are Inadequate To Meet The Residents' Needs

PNH also fails to provide its residents with adequate and appropriate health care in a number of other areas.

1. Neurological Care Is Inadequate

Neurological care and services at PNH are inadequate. PNH primary care physicians, rather than neurologists, provide most of the neurological care at the facility. As a result, many residents with neurological problems, including those with complex and difficult conditions, do not receive the needed specialty services of a neurologist. For example, the PNH physicians did not refer to a neurologist a number of residents who had drug levels that were chronically difficult to control.

In addition, PNH physicians often fail to adequately address residents' anti-seizure medication where they have sub-therapeutic or above therapeutic levels. For instance, for one resident whose Dilantin level fluctuated from high to low to high again, the PNH physician failed to adjust the medication dose, failed to discuss an approach to deal with this problem, and failed to procure expert neurological consult help. The same inadequate documentation and approach was present in the care of another resident who exhibited a high Dilantin level and a sub-therapeutic Tegretol level. As Dr. Adelman concludes for yet another resident, "there is a danger that this resident may be needlessly exposed to medication that is not providing him with any benefit." The City's own on-site reviews reveal a number of similar concerns surrounding neurological care at PNH, including consults not being performed in a timely manner and inadequate documentation of laboratory tests.

PNH also does not have a protocol for proper treatment of emergency seizure situations, known as "status epilepticus." Contrary to generally accepted practice, PNH uses intramuscular injection to treat such emergency situations rather than intravenous treatment. This practice places PNH residents at active risk of harm. In light of the number of PNH residents with seizures and other neurological complications, the

facility's deficiencies in neurological care compromise the health of a significant number of residents.

2. Interdisciplinary Communication Is Inadequate

Interdisciplinary communication between physicians and other health care professionals at PNH is inadequate and does not comport with generally accepted standards. The City's September 1995 on-site review reveals that "interdisciplinary communication is lacking, i.e., no follow-up by other disciplines after findings or recommendations are made." During our tour, even the PNH Medical Director admitted to us that the functioning of the interdisciplinary team needed improvement.

Poor communication between the doctors and the nurses at PNH may have contributed to the death of at least one PNH resident. Dr. Adelman made this conclusion after reviewing the circumstances surrounding the death of a resident who had been receiving Coumadin, a blood thinning medication. Despite the presence of blood in the resident's urine, PNH continued to provide the resident with Coumadin, contrary to accepted professional standards. As Dr. Adelman concluded, this death reveals "a disturbing lack of understanding on the part of nursing about the meaning of [blood in the urine], and therefore, poor communication with the [PNH] physician."

3. Physician Orders Are Inappropriate, Incomplete, Unclear

The orders of the PNH physicians are often inappropriate, incomplete, or unclear. For example, the City's October 1995 on-site review reveals that PNH physicians continue to rely inappropriately on verbal and telephone verbal orders rather than written orders for treatment. The October on-site review also found that physicians' medical diagnoses are often lacking on the physician order sheet. Moreover, Geri Mendelson, our nursing consultant, concludes that physicians' orders are often not clear and that the nurses exacerbate the problem by not taking steps to clarify the orders before trying to implement them. These deficiencies create the danger that orders will not be carried out as intended, thus jeopardizing the health and welfare of the PNH residents who need appropriate treatment.

4. Medical Notes And Documentation Are Inadequate

As is true with psychiatric notes and documentation, PNH general medical notes and documentation are also incomplete and fail to comport with generally accepted standards. PNH physician notes vary dramatically in quality and generally fail to express adequately the needed approach to care for specific issues and to address abnormal medical findings appropriately.

The City's November 1995 on-site review revealed "patterns of non-compliance" with respect to chart notes and documentation. In fact, the on-site review found deficiencies with physician progress notes, physician orders, X-rays, labs and consults. Specifically, the on-site review concluded that physicians' orders were "unacceptable" and that the physicians' progress notes revealed a lack of follow-up to problems identified by staff. The review also found that PPD [purified protein derivative] documentation in the residents' charts is "not complete." During our expert tours of PNH, we also discovered that a large number of resident charts contained no obvious record of PPD test results indicating the presence or absence of tuberculosis. Although many of the charts had a designated sheet to track vaccinations and PPD tests, they were unfilled in half of the charts reviewed. In light of the significant increase in tuberculosis in nursing homes, these deficiencies pose significant risk to PNH residents.

PNH physicians are also failing to complete monthly notes in the residents' charts on a timely basis. The City's November 1995 on-site review found "zero percent" compliance with respect to the completion of monthly summaries. It also found no evaluation of current care plan goals and no review of significant resident issues or episodes occurring during the month.

In addition, PNH often fails to obtain timely laboratory data and weights and to provide appropriate follow-up. We uncovered a number of examples at PNH where there were unacceptably long delays in obtaining consult results, initiating medical tests, obtaining the test results, and providing appropriate treatment. As Dr. Adelman concludes, "[a] better mechanism for tracking tests and obtaining test results in a timely manner should be a priority."

5. Staffing And Resource Concerns

State surveyors in June 1995 found the ratio of physicians to residents at PNH was extraordinarily poor; each PNH physician was responsible for the health care of two hundred or more residents. Just prior to our tour, however, PNH quickly added physicians to its staff. The picture presented to us at the time of our tour was even more skewed because the resident census had been artificially reduced for months due to a ban on admissions and re-admissions that was imposed on PNH after the June 1995 certification survey. At the time of our tour, re-admissions of discharged PNH residents had just resumed, and new admissions were about to start again. Even so, the resident census at the time of our tour was at least 150 residents below where PNH projects it to be in the future. Many of the residents scheduled to be re-admitted were some of the most medically fragile individuals at the nursing home. As Dr. Adelman suggests, given

the artificially reduced census and the presence of new staff physicians, a "re-evaluation" of the medical department should be conducted when the full resident census is reached.

C. Nursing Care And Services At PNH Fail To Meet Generally Accepted Practices

There are deficiencies in the delivery of nursing care and services at PNH which breach generally accepted standards of clinical practice and which seriously jeopardize the residents.

1. Nurses Fail To Follow Standard Infection Control Procedures

PNH nurses fail to adhere to universally accepted treatment protocols with respect to infection control procedures and maintaining aseptic conditions at treatment sites. The PNH Director of Nursing admitted to us that she has concerns about the nursing staff's competency in and knowledge of proper wound care to reduce the possibility of infection. Our nursing consultant concludes that "the PNH nurses did not follow generally accepted procedures to reduce the risk of infection ... and generally did not follow universally accepted procedures related to maintaining cleanliness and sterility ... Generally, the PNH nurses ... did not demonstrate the knowledge or skills to provide appropriate nursing services to residents." The City's own November 1995 on-site review indicates that "[t]reatments did not meet standards of practice utilizing aseptic technique." The City's March on-site review again found that PNH staff do not practice Universal Precautions for infection control, emphasizing that "this area is of serious concern." Once again, it is troubling that PNH failed to correct this deficiency months after it was clearly cited as a problem.

2. Care Of Residents With Diabetes Is Inadequate

PNH fails to provide adequate and acceptable health care to residents with diabetes. Specifically, the practice of evaluating blood sugars and providing subsequent treatment is not acceptable at PNH. Our nursing consultant concludes that the practice of providing care and treatment to PNH residents with insulin dependent diabetes mellitus (a serious form of diabetes) is "not acceptable," and that these residents are "at great risk."

We uncovered many incidents where PNH staff had administered incorrect and/or inaccurate doses of insulin, did not properly monitor certain diabetic residents or inform the physician of their status, and generally did not accurately document insulin administration. In one case, PNH provided a resident with twenty-two straight days of incorrect insulin doses. For another resident who was suffering with an elevated blood sugar level,

PNH failed to provide an appropriate follow-up note about the continuing status of the resident or even a note indicating that the physician had been notified. Our nursing consultant concludes that the nursing practice in this case was "not acceptable," and if left to continue, "could cause harm or even death to the resident." The PNH nursing staff also improperly treated another resident with low blood sugar without first obtaining a physician's order. Our nursing consultant concludes that because this was not done, "the resident could have gone into shock." Dr. Adelman discovered multiple instances where PNH staff failed to follow the generally accepted practice of calling the supervising registered nurse and physician when residents' diabetic levels were too low or too high. We found a number of examples where neither the nurse nor the physician even addressed abnormal blood glucose levels. It appeared in each case that the physician was never notified or not timely notified. Consistent with this finding, the City's October 1995 on-site review reveals that even PNH nursing supervisors fail to obtain a physician's order before treating diabetic residents.

3. Medication Administration Is Inadequate And Nurses Fail To Follow Physicians' Orders

PNH nurses fail to consistently provide accurate and timely medication administration to PNH residents. The use and reporting of controlled drugs is not acceptable at PNH. During our tour, we uncovered many different medication errors that compromise resident care. The City's on-site reviews also conclude that medication passes are unacceptable at PNH, with medication error administration rates as high as thirty-eight percent. One such review found that medication administration records and treatment administration records were all virtually one hundred percent out of compliance with professional standards. The City's review concluded: "These areas reflect repeated gaps in documentation, not just on one dose omission. This is a serious liability and one that must be addressed immediately."

PNH nurses are also not meeting generally accepted standards because they routinely fail to follow physicians' orders which places the PNH residents in jeopardy. During our tour, we discovered that PNH nurses had failed to perform a number of physician-ordered treatments; there was no documentation in the residents' charts as to why the treatments were not done or even that the physician was notified.

4. Skin Care Is Inadequate

PNH fails to perform needed skin assessments on new admittees to determine which residents might be at risk for skin breakdown. Moreover, PNH residents at risk of developing pressure ulcers do not receive required assistance from the

facility to ensure that their activities of daily living are maintained and that their individual physical and functional abilities do not decrease. Once skin breakdowns occur, PNH does not provide adequate and appropriate treatments. Nurses do not treat wounds from skin breakdowns with proper aseptic techniques and do not follow physicians' orders about turning and re-positioning residents.

5. Nutritional Intake Concerns

PNH's practices in a number of areas are not adequate to meet its residents' nutritional needs. First, the facility fails to monitor residents' nutritional intake adequately during meals and fails to provide substitute meals for residents when appropriate. The City has documented these deficiencies repeatedly during its on-site reviews of PNH. Residents have lost significant amounts of weight while under PNH's care, yet the facility fails to weigh residents on a regular basis. When it does weigh residents, the weights are often inaccurate. Even in situations where a significant weight loss is actually accurately recorded, doctors, nurses, and dieticians do not address the problem. During our tour, the PNH dietician acknowledged that the facility has no formal mechanism to notify appropriate health care professionals that residents are losing weight. The City has found other pervasive deficiencies in this area at PNH, including a failure to conduct appropriate nutritional assessments and to provide appropriate diets.

Second, PNH fails to provide adequate assessments and treatment to residents who have swallowing disorders or who cannot eat orally. For example, during its November on-site review, the City found that the facility's therapist was not following accepted standards of practice in performing screenings to identify residents with swallowing problems. Other reviews have documented deficiencies in PNH's practices with respect to residents who are unable to eat and must be fed with a tube. The deficiencies include a failure to conduct adequate assessments of these residents' dietary needs, a failure to provide residents with sufficient calories, protein, vitamins and minerals, and a failure to make a concerted effort to wean residents off of tube feeders.

Finally, during our tour, we also heard many complaints from residents about the adequacy of food they receive. The resident council meeting minutes are rife with resident complaints about food, drink and meals generally. During our tour, we further discovered that PNH is failing to provide its residents with consistently fresh drinking water. We observed that the residents were left to consume water that had been sitting around for days in a styrofoam cup.

6. Nurses Do Not Timely Respond To Resident Calls For Help

A recurring refrain among residents was that PNH nurses and staff did not respond to resident call bells in a timely manner. A number of residents stated that it has taken nurses over forty-five minutes to respond to resident calls for assistance. In one case, a resident was forced to turn off his oxygen machine to sound a loud alarm just to get the attention of the staff. He said he more regularly uses a flash light siren to attract the staff after they fail to respond to his call bell. We also found that some call bells were not appropriately placed near the more immobile residents so that they could access them.

7. Nursing Documentation Is Inadequate

As is true in the other disciplines discussed above, nursing documentation and charting is deficient at PNH. The City's November 1995 on-site review reveals "patterns of non-compliance" with respect to PNH nursing chart notes and documentation. In fact, the on-site reviews found deficiencies with nursing history and assessment, nurses notes, monthly nursing summaries, weights and vital signs, medication and treatment cardexes, care plans, dietary and skin assessments. Similar findings, including the need for inservicing nursing staff about appropriate documentation, appear in earlier on-site City reviews of PNH.

8. Nurse Staffing Is Inadequate

Nurse staffing levels are unacceptable at PNH. The City's own on-site review acknowledges that "[s]taffing continues to be an issue." At the time of our tour, there were many nursing vacancies and an unacceptably high use of contract nurses. The PNH Director of Nursing admitted to us that current permanent nurse staffing is not sufficient and that the facility must rely instead on contract nurses to meet residents' needs. The figures contained in the City's on-site reviews reveal "significant" use of contract agency nurses at PNH: in October 1995, PNH used agency nurses for about twenty-six percent of its registered nurse positions, and used agency nurses for over seventy-one percent of its licensed practical nurse positions. Not only is the overuse of contract nurses inefficient and costly, but it also compromises resident care. The PNH Director of Nursing admitted that the use of agency nurses poses problems with continuity of care. The City's on-site review also concurs with this conclusion.

9. Nurses Require Additional Education/Inservices

Nurses, indeed staff in a broad range of disciplines at PNH, need better education about how best to care for PNH residents. Dr. Adelman concluded that PNH nurses had insufficient knowledge and experience to meet the residents' needs. Members of the PNH

infection control team also acknowledged that staff education is an area that needs improvement at the facility. Some of the other areas in need of additional training that PNH administrators and staff identified include: basic quality nursing care, assessment skills, prevention strategies, interdisciplinary communication, general staff inservicing, and documentation.

In sum, the deficiencies in medical and nursing care at PNH outlined above constitute a systemic failure to meet residents' health care needs, in violation of their constitutional and federal statutory rights.

IV. CERTAIN PNH RESIDENTS ARE NOT BEING SERVED IN THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS

Finally, some PNH residents' rights are being violated as a result of their continuing confinement at the facility. Pursuant to Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." Applicable ADA regulations provide: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). In a recent case involving PNH, the Court of Appeals for the Third Circuit held that Idell S., a PNH resident, had a right under the ADA to receive the support services she needed in her own home rather than being required to live in a nursing home to receive them since Pennsylvania already had a program to provide in-home attendant care services. Helen L. v. DiDario, 46 F.3d 325 (3d Cir.), cert. denied, __ U.S. __, 116 S. Ct. 64 (1995).

There is a group of individuals with physical disabilities at PNH, like Idell S. in the Helen L. case, who professionals have evaluated and determined can live outside of the nursing home with appropriate attendant care services. Also like Idell S., the only reason these individuals must continue to live at PNH is because of a lack of available attendant care services in the Philadelphia area. As the Federal Court of Appeals for the Third Circuit has already decided, this is not an acceptable reason under the ADA to deny individuals the opportunity to be served in a more integrated setting. In addition, mentally ill PNH residents have not been evaluated by professionals to determine whether they can be served in a more integrated setting. The facility's failure to assess these individuals to determine whether continued confinement in a nursing home is necessary or whether there is a more integrated setting appropriate to meet their needs is also a violation of the ADA.

V. MINIMAL REMEDIAL MEASURES

In order to remedy these deficiencies and to protect the rights of PNH residents, the following measures, at a minimum, need to be implemented promptly.

1. PNH must fully comply with all applicable provisions of the Medicare and Medicaid statutes and their implementing regulations that govern conditions of care at PNH.

2. PNH must ensure that the staff members are providing residents with appropriate basic care services that meet the residents' needs.

3. PNH must provide a safe environment for its residents. Staff members must adequately monitor and safeguard the residents, especially those with histories of exhibiting behaviors that cause injury to themselves or others. Residents must be protected from being victimized by other aggressive residents.

4. PNH must provide residents with sufficient, meaningful activities. For those residents who abuse alcohol, PNH must provide them with appropriate productive activities and programming to address their alcohol abuse.

5. PNH must ensure that bodily restraints are used only pursuant to accepted professional standards and that they are never used as punishment or for the convenience of staff. Appropriate physicians' orders must be obtained and followed before restraints are utilized. The facility must ensure that residents are released from any restraints at least every two hours.

6. PNH must provide adequate and appropriate psychiatric and mental health services in accordance with accepted professional standards to residents who need such services. PNH must procure adequate psychiatry consult hours to meet the needs of the residents. Psychotropic medication must only be used in accordance with accepted professional standards and where there is an appropriate psychiatric or neuropsychiatric diagnosis. It must not be used as punishment, in lieu of a training program, for behavior control, or for the convenience of staff. In order to accomplish this, PNH must:

   a. Conduct a comprehensive assessment of each PNH resident receiving psychotropic medication or who has documented mental illness; provide the resident with an appropriate differential diagnosis of mental illness;

   b. Develop an overall treatment plan for each resident with a diagnosis of mental illness that describes clear,

objective and measurable short-term, intermediate and long range goals and objectives for each resident, including time frames for the achievement of each;

c. Provide on-going monitoring of the efficacy of treatment and make revisions in the treatment plan when warranted;

d. Document that, prior to using psychotropic medication for behavior modification, other, less restrictive techniques have been systematically tried and have been demonstrated to be ineffective;

e. Develop and implement an adequate system for detecting, reporting, and responding to any drug-induced side effects of psychotropic medication; and

f. Provide an adequate array of non-pharmacological mental health services for those residents who need them, with special emphasis on those individuals who have exhibited aggressive or other maladaptive behaviors.

7. PNH must ensure that its residents receive adequate preventive, chronic, routine, acute, and emergency medical care in accordance with generally accepted standards of care. PNH must ensure adequate and appropriate interdisciplinary communication among relevant professionals, and PNH physicians must write appropriate, complete and clear orders pursuant to generally accepted practice. Further, PNH primary care physicians must:

a. Conduct comprehensive evaluations of all residents for whom they are responsible;

b. Determine what specialized medical services are required for the residents for whom they are responsible and ensure that such services are timely provided whenever necessary to evaluate or treat the individual's medical problems;

c. Ensure that each individual has an integrated medical plan of care to address any chronic medical problem; and

d. Ensure that each individual's medical status and progress in response to the individual's medical plan of care is regularly and adequately reviewed.

In concert with the above steps, PNH must provide adequate and appropriate routine, chronic, and emergency seizure management to all individuals with epilepsy at PNH in accordance with accepted professional standards of care. Specifically, the City must procure a sufficient number of neurology consult hours to meet the needs of the residents, provide adequate seizure documentation and recordkeeping, and improve diagnostic

techniques. PNH must put in place an emergency protocol for the treatment of status epilepticus and "inservice" staff on how to implement it. PNH must immediately stop the use of intramuscular medication to treat status.

8. PNH must ensure that its residents receive adequate nursing care, and that nurses perform their responsibilities in keeping with accepted professional standards of care by adequately identifying health care problems, notifying physicians of health care problems, monitoring and intervening to ameliorate such problems, and keeping appropriate records of residents' health care status. To this end, PNH nurses must:

a. Conduct adequate, comprehensive assessments;

b. Develop nursing diagnoses and develop and implement adequate and appropriate comprehensive nursing care plans to address each resident's health care needs;

c. Routinely perform on-going monitoring of serious medical conditions, including such basic procedures as taking vital signs and measuring weights;

d. Develop and implement a system for recording important information about a resident's status to monitor changes;

e. Communicate essential information to physicians; and

f. Follow physicians' orders.

In addition, PNH nurses and staff must ensure that they follow standard infection control procedures, maintain aseptic technique and conditions at treatment sites, ensure that diabetic residents receive appropriate care and services, reduce medication errors, perform skin care assessments and ongoing treatments and therapy to prevent skin breakdown, and respond promptly to resident calls for assistance. The City must also procure sufficient nursing staff to ensure adequate continuity of resident care so that the facility is no longer reliant on temporary contract nurses.

9. PNH must ensure that residents' nutritional intake is adequate, that weights are routinely and accurately recorded, and that residents receive appropriate diets, adequate amounts of food, and sufficient quantities of fresh water to ensure proper hydration. In addition, PNH must assess and treat residents with swallowing problems and residents who are unable to eat orally in accordance with accepted professional procedures.

10. PNH must establish and maintain an adequate, unified record for each individual that comports with accepted professional standards and includes current information with respect to the

individual's care, medical treatment, and training, and must require staff to utilize such records in making care, medical treatment and training decisions.

11. The City must ensure that a sufficient number of professional and non-professional staff, including outside consultants, are employed to fully meet the needs of the PNH residents.

12. PNH must comply with the clinical practice guidelines on the treatment of pressure ulcers promulgated by the Public Health Service of the United States Department of Health and Human Services.

13. PNH must ensure that the staff members are adequately trained to perform its duties. PNH must implement a training program for all personnel, including physicians, nurses and dieticians regarding, at a minimum, nutrition, wound care and infection control, abuse and neglect, appropriate drug therapies for the elderly, mental health needs of residents, and a coordinated interdisciplinary approach to providing care to residents.

14. PNH must implement professional decisions that a resident can be served in a more integrated setting by transferring the resident to the alternative setting. The City of Philadelphia must ensure that before any resident is transferred to a more integrated setting, the setting is capable of meeting the resident's needs and, once the transfer takes place, that the resident's needs are met. Residents who are mentally ill must be assessed to determine whether they are being served in the most integrated setting appropriate to their needs.

The remedial measures outlined above are the minimal steps needed to redress the constitutional and statutory deficiencies at PNH. In order to ensure compliance with the remedial measures, an effective monitoring and reporting scheme is essential.

Given our positive experience with the City thus far, we hope to be able to resolve this matter amicably and cooperatively. As such, we will be contacting your attorneys in the near future to arrange a meeting to discuss in greater detail the measures needed to fully remedy the deficiencies outlined above. We look forward to working with you to resolve this matter in a reasonable and practical manner.

If you have any questions, please contact Richard Farano at 202-307-3116, or David R. Hoffman at 215-451-5337.

Sincerely,

Devai L. Patrick
Assistant Attorney General
Civil Rights Division

cc: Stephanie Franklin-Suber, Esq.
Acting City Solicitor
City of Philadelphia
Law Department

Ms. Estelle B. Richman
Commissioner
City of Philadelphia
Health Department

Ms. Mollie Hess
Executive Director
Philadelphia Nursing Home

Michael R. Stiles, Esq.
United States Attorney
Eastern District of Pennsylvania